

**AUTHORIZATION TO RELEASE MEDICAL, SURGICAL,
PSYCHIATRIC CARE AND TREATMENT INFORMATION**

CDCR 1053 (REV. 03/08)

To:

I hereby request and authorize you to disclose, whenever requested to do so by the California Department of Corrections and Rehabilitation or its representatives, any and all information you may have concerning the undersigned, _____ with respect to all medical, surgical, or psychiatric care and treatment, including, but not limited to copies of all medical and hospital records and reports in your possession.

This authorization is executed by me for the purpose of allowing an investigation and evaluation by the California Department of Corrections and Rehabilitation and its representatives in respect to my request for an endorsement to carry a concealed weapon.

The information and/or records obtained by means of this authorization may be disclosed to authorized personnel of the California Department of Corrections and Rehabilitation and its agents for the purpose of investigation and evaluation of my request.

This authorization shall be valid for a period of 72 months from the date of execution. A copy of this authorization shall be available to me upon demand. A photocopy of this authorization shall be considered as effective and valid as the original.

SIGNATURE	DATE
ADDRESS	DATE OF BIRTH
	SOCIAL SECURITY NUMBER